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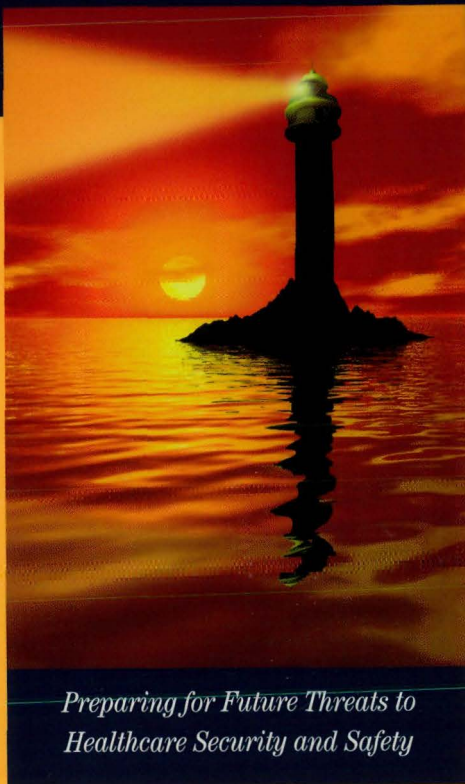
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Violence prevented: the anatomy of a near miss

Drew Neckar, CPP

Although actual shootings in hospitals may occur rather infrequently, incidents that threaten such outcomes occur with more regularity than any of us would like to admit, the author says. In this article he relates such an incident, which, thanks to the combination of an engaged population, effective physical security controls, and an effective response allowed for the successful diffusion of the situation without loss of life.

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Recent mass shootings in hospitals and other public venues across the United States have led to repeated dissection of the senseless loss of life in attempts to determine how it could have been prevented. Suggested mitigation efforts generally fall into three major categories:

- identifying individuals who are likely to commit mass murder,
- keeping weapons from entering a facility
- improving responses in order to limit the loss of life when an incident does occur.

While significant improvements have been made in these areas during the last decades, there are factors that prevent any of them from being an all-encompassing solution.

RESPONDING TO EARLY WARNING SIGNS

Most of those who take the leap to commit mass murder exhibit

early warning signs that, if properly interpreted and responded to, may provide an opportunity to prevent them from taking that final step and taking the lives of others. Unfortunately, there are millions of individuals who exhibit at least some of these warning signs. Only a small fraction of them will ever entertain the idea of mass murder, let alone devise a plan and act on it. Once we factor in privacy laws and hesitations with sharing critical information, it becomes unrealistic to expect that the majority of those who are planning to commit mass murder will be effectively identified and deterred.

WEAPONS DETECTION

Weapons detection technology is becoming increasingly effective, but deployment of metal detectors at all of a facility's entrances is a significant capital investment and the ongoing staffing requirements to operate them place a significant financial burden on an organization. These factors, coupled with the inconvenience to visitors and the public relations impact of appearing "unsafe," make their deployment unfeasible in all except the high-

est threat environments. Even if an organization determines that all of these costs are acceptable, it may only displace the shooting from happening deeper inside the facility to the crowded lobby area where masses of visitors and employees are waiting for screening.

ARMED RESPONSE TIMES

When warning signs go undetected, intervention is not successful, or the individual enters the facility undetected, the majority of events only end once an armed response can be brought to bear¹. Historical data shows that the speed at which an active shooter incident evolves can easily result in four or more victims per minute, and the response time that can be expected for an effective police response in most areas in the United States can be five to six minutes².

SECURITY'S DUTY: REDUCING THE PROBABILITY AND MITIGATING THE LOSS OF LIFE

Based on these factors, it is safe to assume that not all individuals planning to take lives in this manner will be detected and stopped

through behavioral analysis or weapons detection, and that if an individual begins shooting with the intent to take lives, there will be casualties regardless of how well the response is designed.

A recent study³ conducted by John's Hopkins researchers postulates that due to the rarity of hospital mass shootings and the challenges presented in securing the healthcare environment that "zero risk is not attainable." While this is true, it is the duty of the security professional to evaluate what measures their security program can take to reduce the probability of active shooter incidents and to mitigate the loss of life if one does occur. There are many measures specific to active shooter response that can be implemented, but the elements of a properly designed and integrated healthcare security program also can play a significant role in preventing an incident from occurring. This can be explored through the analysis of an actual incident where the coordination of these elements prevented mass murder in a hospital.

THE INCIDENT

It was a beautiful spring Satur-

day morning, in a mid-size city in the heartland of the United States. No one at the 300-bed acute care hospital was thinking about the shooting that had left three dead in the sixth floor Critical Care unit of a similar hospital in Georgia less than a month earlier. No one that is except one man.

10:05 a.m.: The subject, a 43-year-old homeless man with a history of mental illness who had recently stopped taking his medication, enters the hospital through an unlocked entry door and blends into the crowds of visitors and staff, making his way to the cafeteria.

10:15 a.m.: A cafeteria staff member becomes suspicious of the man who has been loitering in the area for several minutes, noting that his long black trench coat and uneasy demeanor don't fit with the rest of the customers. When she approaches him to ask if he needs assistance, he mutters "it's OK, I have a permit for it" while patting a bulge on his hip and hurriedly leaves the cafeteria.

10:17 a.m.: The cafeteria staff member feels that the incident was odd enough that she contacts the hospital's Security Depart-

ment and gives them the details of her observation and interactions with the man. The security officer in the hospital's control center immediately notifies patrolling security officers of the suspicious person and calls local police to inform them of the possible developing situation while beginning a review of the hospital's video surveillance system to determine where the man had gone after leaving the cafeteria.

10:18 a.m.: Using video surveillance, the security officer in the control center is able to identify the man and track his movements, placing him in a specific wing of the 2 million-square-foot facility. Via two-way radio, the officer notifies patrolling security officers of the probable location of the suspect, and then calls local 911 dispatch to inform them that the possibly armed suspect is still inside the facility.

10:19 a.m.: Two security officers locate the man outside of an inpatient unit on the sixth floor of the hospital, where he is talking to one of the nurses. The nurse later recounted that he was asking directions to the Critical Care Unit and seemed "scary." The security

officers approach the man and request that he open his trench coat. He at first refuses and then begins to reach inside of the coat toward his waist. The security officers, determining that this is a hostile movement, physically take the man to the ground, in the process revealing a holstered pistol concealed under his coat. After a brief struggle, the security officers are able to gain control of the man, place him in handcuffs, and disarm him of the .44 Magnum revolver strapped to his waist and the stashes of additional ammunition in his pockets.

10:21 a.m.: The first police response units arrive on site. Acting on information relayed from the Security Control Center through the 911 operator, the police respond directly to the area where the security officers have the suspect and take him into custody, arresting him for carrying a concealed weapon and disorderly conduct.

Later during interviews by police, the man explained that a college professor, who he considered his "mentor," had died in the hospital's Critical Care Unit several years earlier, and he had made the

decision that day that he needed to come to the Critical Care Unit to “release my demons.” While police could not release all of the details of the interviews, the chief did later contact the hospital’s security manager and tell him that he had no doubt that if it were not for the security officers’ timely response, people would have died that day. The man was later released and charges were dismissed, on condition that he submit to court-ordered and monitored psychiatric care.

ANALYSIS

This incident was resolved without any serious negative consequences for anyone involved, but what made it different from others that haven’t? More importantly, what can we learn from these differences and what can be done to replicate these conditions?

It is arguable that the end result was derived from three relatively simple things that went right. All of these are essential elements of any physical security program, without which the end result of this incident would have undoubtedly been tragic and extremely costly for the healthcare organization involved.

An Actively Engaged Employee Population

The first of these was an actively engaged employee population. The Dietary Department worker who first contacted the man could easily have been too busy helping other customers to notice someone who “just didn’t look right.” How easy would it have been for her to fall into the “it’s not my job” mentality and ignore her internal threat assessment radar? Yet she didn’t do either of these things. Starting the day she was hired in new employee orientation, security awareness in the facility was emphasized--not as a scare tactic--but to engaged the entire employee population as the eyes and ears of the security program.

We can never be certain that this training helped her recognize what “suspicious” is, have the courage to approach the man, or know where to turn to report something that wasn’t right, but we can say with some certainty that employees who have been empowered in this way will be much more likely to consider security to be a part of their job.

Effective Security Design Of the Facility

Effective security design of the facility restricted the subject to a limited number of public areas, allowing the Security Department, once notified, to quickly locate the general area he was in through effective use of technology. Similar to many healthcare facilities, extensive remodeling had been done to this hospital through the years. The Security Department had been involved early in the process of these redesigns and had successfully convinced the architects to employ crime prevention through environmental design principals defining public versus employee only spaces.

While it would be beyond the financial abilities of any organization to cover every square foot of the facility with video surveillance, a more limited footprint for the “public” had allowed for more effective deployment of video surveillance technology concentrated on “choke points” in public spaces. This allowed for quick and effective tracking of an individual through the facility, and without it, would have required a virtual army of security officers

and hours of time to search the two million plus square foot facility.

An Effective Response Capability

An aware and engaged employee population and effective security design and technology deployment could have done nothing to stop the incident from unfolding without an effective response capability. Once the threat had been identified and located, it required well-trained and equipped “boots on the ground” to render the threat harmless.

While this facility could easily have been considered understaffed with only two security officers and a dispatcher to provide protection for millions of square feet and thousands of employees, patients and visitors, the officers had been carefully selected and given the tools to do their jobs. The officers working that day were the product of a hiring process that carefully screened applicants to select only those best suited. Once hired, they had been put through an extensive training program to give them the specific knowledge and skills to work within the healthcare envi-

ronment. This was supplemented by ongoing training, not just in those areas required by accrediting agencies and state law, but also in verbal de-escalation techniques, threat recognition, and unarmed defense and arrest tactics.

They had also been trained, equipped, and given authorization to use tools which enabled them to quickly gain control of the subject and to detain him until he could be handed over to law enforcement authorities. These officers also had the benefit of the force multiplier of effective communication tools--radio communication with the dispatcher and between the officers themselves --allowing for a quick and coordinated deployment.

While actual shootings in hospitals occur rather infrequently⁴,

incidents similar to this happen with more regularity than any of us would like to admit. In most cases, the combination of an engaged population, effective physical security controls and an effective response allow for the successful diffusion of the situation without loss of life.

NOTES:

¹ New York Police Department. (2011). Active Shooter: Recommendations and Analysis for Risk Mitigation, New York City Police Department.

² <https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=245861>

^{3, 4} Kelen, G. MD; Catlett, C. MD; Kubit, J. MD; Hsieh, Y PhD (2012) Hospital Based Shootings in the US: 2000 to 2011, Annals of Emergency Medicine.